

Application for Assistance

Date Received _____

Assigned to _____

Is an **EBT** card needed? ☐ Yes ☐ No

Check **only** those programs for which you are applying:

- ☐ Child Care Assistance Program (CCAP)
- ☐ Family Independence Temporary Assistance Program (FITAP)
- ☐ Kinship Care Subsidy Program (KCSP)
- ☐ Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program)

You can begin to apply and establish your application date by filling in your name, address and signature below and give this form to us today. It will help us to process your application faster if you also give us a telephone number where you can be reached during the day and **provide a copy of a photo ID or other proof of identity.**

Can you read and understand English? (¿Puede leer usted y poder comprender ingles?) ☐ Yes (Sí) ☐ No

If **No**, what language can you read and understand? (¿Si no, qué idioma le puede lee y comprende?) _____

(Last Name)	(First Name)	(Middle Name)	Social Security Number
Street or Rural Route	Apt. or Lot#	City and State	Zip Code

Mailing Address if different from above: _____

Your Signature

What if you need SNAP benefits right away?

We may be able to get SNAP benefits to you within 7 days of the date you apply if you qualify. You may qualify if:

- The total amount of money you have received or expect to receive this month is less than \$150 and you have \$100 or less in liquid resources such as cash, savings or checking accounts; or
- Your household's rent/mortgage and utilities are more than your total income and resources; or
- Your household includes migrant or seasonal farm workers.

If any of the above describes your household, answer the following questions:

1. What is the total amount of money that your household will receive this month? Include money from all sources such as earned income, contributions, Social Security, SSI, VA, etc. \$ _____
2. How much money does your household have in liquid resources? Include cash on hand, checking accounts, savings accounts, etc. \$ _____
3. How much is your household's monthly rent or mortgage? \$ _____
4. Do you pay for utilities, such as electricity, gas, water, etc.? ☐ Yes ☐ No
5. Do you pay utility costs for heating or air conditioning? ☐ Yes ☐ No
6. Do you pay telephone expenses? ☐ Yes ☐ No
7. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

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1. Income \$ _____ + 2. Resources \$ _____ = Total \$ _____ (A)	Is #1 less than \$150? <input type="checkbox"/> Yes <input type="checkbox"/> No AND Is #2 less than \$101? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to both, Expedite. If no, consider shelter costs.
3. Rent/Mortgage \$ _____ + Utility Standard* \$ _____ = Total \$ _____ (B)	Is B greater than A? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Expedite. If no, consider migrant or seasonal farm worker status. Is anyone in the household a migrant or seasonal farm worker? <input type="checkbox"/> Yes <input type="checkbox"/> No AND Is #2 less than \$101? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to both, Expedite. If no, the case is not expedited.

*If, on the reverse side, the answer to:
 #4 is Yes **and** #5 is No, use BUA.
 #5 is Yes, use SUA
 #6 is Yes **and** #4 **and** #5 are No, use TEL.

Expedited: ☐ Yes ☐ No If yes, enter "Expedited Date" on CP CA screen of LAMI.

Due Date*: _____

*The case must be certified and the client must have their EBT card in sufficient time to be able to use their SNAP benefits by the 6th calendar day after the date of application. If the 6th calendar day falls on a weekend or holiday, the due date becomes the previous workday.

Expedited status determined by: _____
Signature of Agency Representative Date

A. Tell Us About You

You can choose not to give Ethnicity and Racial information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.

Do you need a new Louisiana Purchase Card? ☐ Yes ☐ No

First Name Middle Initial Last Name Maiden or Other Name

Mailing Address Apt/Lot No. City State Zip Code

Home Address (If different from mailing) Apt/Lot No. City State Zip Code
() () ()

Home Telephone Number Cell Telephone Number Work or Other Telephone Number

Social Security Number Parish of Residence

Date of Birth E-mail Address

Sex: ☐ Male ☐ Female **Ethnicity:** Hispanic/Latino? ☐ Yes ☐ No

Marital Status:

☐ Married
☐ Separated
☐ Divorced
☐ Never Married
☐ Widowed

Racial Heritage (check all that apply):

☐ Asian ☐ Native Hawaiian/
Pacific Islander
☐ White ☐ American Indian/
Alaskan Native
☐ Black or African American

Highest grade level
completed in school? _____

Student? ☐ Yes ☐ No

U.S. Citizen? ☐ Yes ☐ No

If no, do you have
immigration papers? ☐ Yes ☐ No

Date of entry in U.S.: _____

B. Tell Us If You Have An Authorized Representative

An Authorized Representative is someone you allow us to talk with about your SNAP/Child Care Assistance Program benefits. You can name someone, but it is not required.

Would you like to have an Authorized Representative? ☐ Yes ☐ No

If yes, tell us about your Authorized Representative.

Name of Authorized Representative Relationship to Applicant Telephone Number
()

Address City State Zip Code

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Rights and Responsibilities discussed with applicant? ☐ Yes ☐ No

Reporting requirements explained to applicant? ☐ Yes ☐ No

Is an EBT card needed? ☐ Yes ☐ No

Is there an authorized representative? ☐ Yes ☐ No

Identity verified by: ☐ Driver's License ☐ Identification card ☐ Other

Residency verified by:

Marital status verified by:

Reason for application:

FITAP/KCSP explained? ☐ Yes ☐ No

Client selected: ☐ FITAP ☐ KCSP

C. Tell Us About The Other People In Your Household – Do Not Include Yourself

List everyone else who lives in your household, even if you are not applying for them. You can choose not to give Ethnicity & Racial information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.

Don't miss out on No Cost Health Insurance for your children! If you check the box below, we will share what you put on this form with the Louisiana Department of Health and Hospitals (DHH). DHH will sign up children who qualify and send you a letter with more information about the Medicaid Program.

☐ **Yes, please share my information with DHH so I do not need to complete another application.**

I understand that if my children get Medicaid, and their medical bills are paid by a private health insurance or lawsuit settlement, Medicaid can get its money back from this source.

Household Members (Enter Name)	Relation to you (NR=Not Related)	Birth Date	Social Security Number	Sex (M/F)	US Citizen? (Yes/No)	ED Level *	Marital Status	Race/ Ethnic Code **
Last First MI	Complete these sections only for those who need benefits							

****Race:** (You may select more than one race)

****Ethnicity:**

AN = Alaskan Native **WH** = White **BL** = Black or African American

Y = Hispanic or Latino

AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander

N = Not Hispanic or Latino

***ED Level:** List highest grade completed or GED/college

If you need more space for additional household members, you can write the information on plain paper or ask for an "Additional Household Members Form."

If anyone for whom you are applying is not a U. S. citizen, your worker will complete an Alien Addendum and Checklist with you during your interview.

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Household composition: _____ person household

Are all members linked on LAMI? ☐ Yes ☐ No

Enumeration verified by:

Age and relationship verified by:

Document CR 5

Citizenship: Are all household members U.S. citizens? ☐ Yes ☐ No

If no, complete Alien Addendum and Alien Checklist.

D. Tell Us About Your Household		For Office Use Only
Please answer the following questions for yourself and everyone else in your home.		
1. Are you or anyone in your household a fleeing felon?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you or anyone in your household in violation of their probation or parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you or anyone in your household been convicted of a drug-related felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. If yes, complete supplement.
4. Have you or anyone in your household been disqualified or had their benefits reduced or stopped for breaking the rules of SNAP, FITAP, KCSP, or SSI?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. If yes, complete supplement.
5. Do you or anyone in your household need to get away from an abusive situation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. If yes and FITAP/KCSP: Issue Flyer DV
6. Do you or anyone in your household have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. If yes, complete supplement. If FITAP, complete OFS 90 or OFS 90L.
7. Are immunizations current on all children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Verification: <input type="checkbox"/> OFS IM <input type="checkbox"/> CR 9 <input type="checkbox"/> LINKS
If no, who? _____ Why? _____		
8. Does anyone in your household attend high school, college, vocational or technical school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. If yes, is anyone attending an institution of higher education? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, complete the following for each student:		If yes, complete supplement.
a. _____		<input type="checkbox"/> Eligible student
Name of Student _____ Name of School and Program of study _____		<input type="checkbox"/> Ineligible student
How many hours does the student attend school each week? _____		
Is this considered full or part-time? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
b. _____		<input type="checkbox"/> Eligible student
Name of Student _____ Name of School and Program of study _____		<input type="checkbox"/> Ineligible student
How many hours does the student attend school each week? _____		
Is this considered full or part-time? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
9. Are you or anyone in your household pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who? _____ Due date: _____		
10. Do you usually buy food and prepare your meals with everyone who lives with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, who buys and prepares their food separately? _____		
11. Have you or anyone in your household received cash assistance or SNAP benefits in Louisiana or from another state?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. If yes, who? _____		
b. When? _____		
c. What state(s)? _____		
12. Do you or anyone in your household have an application pending for any benefits that you are not receiving yet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. If yes, what type?

E. Tell Us About Your Household's Work		For Office Use Only
<p><i>Tell us about any money received by you or anyone in your household for work including full-time, part-time, temporary, or seasonal jobs, self-employment, training, military reserve pay, or work study. This includes money received from wages, salaries, tips, or commissions.</i></p>		
<p>1. Do you or anyone in your household work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>Complete the following information for each person who works for an employer. If anyone works for more than one employer, complete a separate block for each employer. Use plain paper if you need more space.</p>		
<p>2. Person Who Works For An Employer</p>		Use OFS 3
<p>Name _____ Start Date _____</p>		Verified by:
<p>Employer's Name _____ Phone # _____</p>		
<p>Address _____</p>		
<p>How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____</p>		
<p>Are reimbursements received? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p># of hours worked per week _____ Hourly wage _____</p>		
<p># of days worked per week _____</p>		
<p>Do you ever work overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		Is commission earned?
<p>If yes, how often? _____ How many hours? _____</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are tips earned? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		If yes, how much?
<p>If yes, how much? _____ How often? _____</p>		How often?
<p>Is this Work Study? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		Is this piecework?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Rate per piece?
<p>3. Person Who Works For An Employer</p>		Use OFS 3
<p>Name _____ Start Date _____</p>		Verified by:
<p>Employer's Name _____ Phone # _____</p>		
<p>Address _____</p>		
<p>How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____</p>		
<p>Are reimbursements received? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p># of hours worked per week _____ Hourly wage _____</p>		
<p># of days worked per week _____</p>		
<p>Do you ever work overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		Is commission earned?
<p>If yes, how often? _____ How many hours? _____</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are tips earned? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		If yes, how much?
<p>If yes, how much? _____ How often? _____</p>		How often?
<p>Is this Work Study? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		Is this piecework?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		Rate per piece?
<p>4. Is anyone on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>5. Has anyone in your household (including you) stopped working in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		5. If yes, complete supplement.

Complete the following information for each person who is self-employed. This includes fishermen, child care providers, hair dressers, and people who do odd jobs such as cutting grass, picking up cans, etc. Use plain paper if you need more space.				For Office Use Only																									
6. Persons Who Are Self-Employed				6. Verified by:																									
				<input type="checkbox"/> Prior year's income tax return <input type="checkbox"/> Accountant or bookkeeper records <input type="checkbox"/> Personal business records																									
Name		Name																											
Type of Business		Type of Business																											
Monthly Business Income		Monthly Business Income																											
Monthly Business Expenses		Monthly Business Expenses																											
# Hours Worked Per Week		# Hours Worked Per Week		7. If yes, complete supplement.																									
7. Is anyone in your household (including you) looking for work? <input type="checkbox"/> Yes <input type="checkbox"/> No																													
8. Is anyone in your household a migrant or seasonal farm worker? <input type="checkbox"/> Yes <input type="checkbox"/> No																													
9. Do you or anyone in your household rent a room? <input type="checkbox"/> Yes <input type="checkbox"/> No																													
10. Do you or anyone in your household pay someone else in your home for meals? <input type="checkbox"/> Yes <input type="checkbox"/> No																													
F. Tell Us About Other Income																													
1. Do you or anyone in your household receive money from a source other than work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , check each type of income. <table style="width: 100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Annuity Income</td> <td><input type="checkbox"/> Roomer/Boarder</td> </tr> <tr> <td><input type="checkbox"/> Child Support Income</td> <td><input type="checkbox"/> Social Security</td> </tr> <tr> <td><input type="checkbox"/> Contributions From Family/Friends</td> <td><input type="checkbox"/> Scholarships/Grants/School Loans</td> </tr> <tr> <td><input type="checkbox"/> Disability Insurance Benefits</td> <td><input type="checkbox"/> SSI</td> </tr> <tr> <td><input type="checkbox"/> Energy Check</td> <td><input type="checkbox"/> Spousal Support/Alimony</td> </tr> <tr> <td><input type="checkbox"/> Interest Income</td> <td><input type="checkbox"/> Tribal Money</td> </tr> <tr> <td><input type="checkbox"/> Loans</td> <td><input type="checkbox"/> Training Allowance (WIA)</td> </tr> <tr> <td><input type="checkbox"/> Military Allotment</td> <td><input type="checkbox"/> Trust Income</td> </tr> <tr> <td><input type="checkbox"/> Oil Lease/Royalties</td> <td><input type="checkbox"/> Unemployment Benefits</td> </tr> <tr> <td><input type="checkbox"/> Railroad Benefits</td> <td><input type="checkbox"/> Veterans Benefits</td> </tr> <tr> <td><input type="checkbox"/> Rental Income</td> <td><input type="checkbox"/> Workers Compensation</td> </tr> <tr> <td><input type="checkbox"/> Retirement Pension</td> <td><input type="checkbox"/> Other</td> </tr> </table>						<input type="checkbox"/> Annuity Income	<input type="checkbox"/> Roomer/Boarder	<input type="checkbox"/> Child Support Income	<input type="checkbox"/> Social Security	<input type="checkbox"/> Contributions From Family/Friends	<input type="checkbox"/> Scholarships/Grants/School Loans	<input type="checkbox"/> Disability Insurance Benefits	<input type="checkbox"/> SSI	<input type="checkbox"/> Energy Check	<input type="checkbox"/> Spousal Support/Alimony	<input type="checkbox"/> Interest Income	<input type="checkbox"/> Tribal Money	<input type="checkbox"/> Loans	<input type="checkbox"/> Training Allowance (WIA)	<input type="checkbox"/> Military Allotment	<input type="checkbox"/> Trust Income	<input type="checkbox"/> Oil Lease/Royalties	<input type="checkbox"/> Unemployment Benefits	<input type="checkbox"/> Railroad Benefits	<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Rental Income	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Retirement Pension	<input type="checkbox"/> Other
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For Office Use Only		FITAP		SNAP																									
Name	Age	WR Code	Reason For Exemption	WR Code	Reason For Exemption																								

2. For each box checked in #1 of this section on page 5, complete the following information. Include any money you expect to receive in the next 30 days.					For Office Use Only Verified by:													
Name	Type Of Income	Amount	How Often (Weekly, Monthly, etc)	<div style="text-align: right;">Do You Expect This Income To End</div> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?														
3. Is someone court-ordered to pay child support to you or anyone in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
4. Do you or anyone in your household receive any money from a child's parent who is not court-ordered to pay? <input type="checkbox"/> Yes <input type="checkbox"/> No																		
G. Tell Us About Your Expenses																		
<i>In order to receive the most benefits possible, you need to tell us about your household expenses. Failure to report any of the expenses listed below will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.</i>																		
HOUSING EXPENSES																		
1. Check each type of housing expense that you or anyone in your household has. <table style="width: 100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> Rent</td> <td><input type="checkbox"/> Electricity</td> </tr> <tr> <td><input type="checkbox"/> Mortgage(s), (if buying)</td> <td><input type="checkbox"/> Gas</td> </tr> <tr> <td><input type="checkbox"/> Lot Rent</td> <td><input type="checkbox"/> Sewer</td> </tr> <tr> <td><input type="checkbox"/> Homeowner's Insurance</td> <td><input type="checkbox"/> Water</td> </tr> <tr> <td><input type="checkbox"/> Flood Insurance</td> <td><input type="checkbox"/> Garbage</td> </tr> <tr> <td><input type="checkbox"/> Property Tax</td> <td><input type="checkbox"/> Telephone</td> </tr> <tr> <td><input type="checkbox"/> Condominium Fees</td> <td><input type="checkbox"/> Other</td> </tr> </table>					<input type="checkbox"/> Rent	<input type="checkbox"/> Electricity	<input type="checkbox"/> Mortgage(s), (if buying)	<input type="checkbox"/> Gas	<input type="checkbox"/> Lot Rent	<input type="checkbox"/> Sewer	<input type="checkbox"/> Homeowner's Insurance	<input type="checkbox"/> Water	<input type="checkbox"/> Flood Insurance	<input type="checkbox"/> Garbage	<input type="checkbox"/> Property Tax	<input type="checkbox"/> Telephone	<input type="checkbox"/> Condominium Fees	<input type="checkbox"/> Other
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<input type="checkbox"/> Condominium Fees	<input type="checkbox"/> Other																	
2. For each box checked in #1 of this section, complete the following information.																		
Type Of Housing Expense	Name and Phone Number of Person or Company Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)															

Are insurance and property taxes included in the mortgage payment? <input type="checkbox"/> Yes <input type="checkbox"/> No Are any of these bills past due? <input type="checkbox"/> Yes <input type="checkbox"/> No	Living Arrangement <input type="checkbox"/> Public housing <input type="checkbox"/> HUD or Section 8 subsidy <input type="checkbox"/> Other subsidy <input type="checkbox"/> No rent subsidy
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Indicate how each expense was verified.	Eligible for: <input type="checkbox"/> SUA <input type="checkbox"/> BUA <input type="checkbox"/> TEL <input type="checkbox"/> None
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<p>3. Do you pay housing expenses for a home you are no longer living in but plan to return to? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Is your household responsible for paying a utility bill for using a heater or air conditioner? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Does anyone help you pay your housing expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you receive energy assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the assistance through the Low-Income Home Energy Assistance Program (LIHEAP)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Is any of the rent you pay used to pay utilities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>For Office Use Only</p> <p>5. If yes, complete supplement.</p>																
<p>DEPENDENT CARE EXPENSES</p>																	
<p>1. Do you or anyone in your household pay someone to care for a child, or an adult who is elderly or disabled, so that you or a household member can work, attend training or school, or look for work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. If yes, complete the following information.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Paid For Whom</th> <th style="width: 30%;">Name And Telephone Number Of Person Paid</th> <th style="width: 15%;">Amount Paid</th> <th style="width: 30%;">How Often Paid (Weekly, Monthly, Etc.)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>3. Does anyone help you pay your dependent care expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Paid For Whom	Name And Telephone Number Of Person Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)													<p>Certified for CCAP? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is co-payment amount?</p> <p>3. If yes, complete supplement.</p>
Paid For Whom	Name And Telephone Number Of Person Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)														
<p>CHILD SUPPORT EXPENSES</p>																	
<p>1. Does anyone in your household pay court-ordered child support? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following information.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Who Pays</th> <th style="width: 25%;">Paid to Whom</th> <th style="width: 15%;">Amount Paid</th> <th style="width: 35%;">How Often Paid (Weekly, Monthly, Etc.)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Who Pays	Paid to Whom	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)									<p>Court-ordered child support expenses:</p> <p>Medical expenses: Use form SNAP 1MW</p>				
Who Pays	Paid to Whom	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)														
<p>MEDICAL EXPENSES</p>																	
<p><i>We can allow a medical deduction in your SNAP case for each household member who has a disability or is over the age of 59. A deduction may be given for medical expenses that are more than \$35.00 per month.</i></p> <p>1. Is there anyone in your household who has a disability or is over the age of 59? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, answer the questions in this section. If no, skip to the Household Resources section on the next page.</p> <p>2. Does this person have to pay medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. If yes, do you want to verify these expenses so that you can receive a medical deduction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Check each medical expense that this person has.</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Dental Bills</td> <td><input type="checkbox"/> Prescribed Medicine</td> </tr> <tr> <td><input type="checkbox"/> Hospital Bills</td> <td><input type="checkbox"/> Prescription Drug Plan</td> </tr> <tr> <td><input type="checkbox"/> Health Insurance Or Medicare Premiums</td> <td><input type="checkbox"/> Premium</td> </tr> <tr> <td><input type="checkbox"/> Medical Appliances</td> <td><input type="checkbox"/> Nursing Home</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> </tr> </table>		<input type="checkbox"/> Dental Bills	<input type="checkbox"/> Prescribed Medicine	<input type="checkbox"/> Hospital Bills	<input type="checkbox"/> Prescription Drug Plan	<input type="checkbox"/> Health Insurance Or Medicare Premiums	<input type="checkbox"/> Premium	<input type="checkbox"/> Medical Appliances	<input type="checkbox"/> Nursing Home		<input type="checkbox"/> Other						
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<input type="checkbox"/> Medical Appliances	<input type="checkbox"/> Nursing Home																
	<input type="checkbox"/> Other																

3. For each box checked in # 2 on page 7, complete the following information.				For Office Use Only
Names	Type of Expense	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)	
<i>Medical Transportation Expense is money spent for trips to the doctor, hospital, drug store, etc. This includes miles driven in your own vehicle.</i>				
4. Does any elderly or disabled person listed on previous page have medical transportation costs? <input type="checkbox"/> Yes <input type="checkbox"/> No				
a. Does this person use their own vehicle or a household member's vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No				
b. If yes , complete the following information.				
Name Of Person	List All Places Visited For Medical Purposes (Ex. Doctors, Drug Store, Hospital, Etc.)	# Of Miles Traveled Round Trip	Number Of Visits Per Month	
c. Does this person pay someone other than a household member for medical transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
d. If yes , complete the following information.				
Name Of Person	Who Is Paid	Where Does This Person Go	How Much Does This Person Pay Per Trip	
<i>If you need more space, you can write the information on plain paper.</i>				
5. Will you or anyone in your household be reimbursed for any of the medical expenses listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. Does anyone help pay the medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No				

5. If yes, complete supplement.

6. If yes, complete supplement. When management is questionable, use form OFS 4MW.

H. Tell Us About Your Household's Resources				For Office Use Only															
<i>Resources include cash, money in the bank, Certificates of Deposit, stocks, and bonds. Resources do not include personal property such as jewelry, furniture, electrical equipment, or clothing.</i>																			
1. Check each resource listed below that you or anyone in your household has. <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Bank/Credit Union Account (Checking) <input type="checkbox"/> Bank/Credit Union Account (Saving) <input type="checkbox"/> Joint Account <input type="checkbox"/> Bonds <input type="checkbox"/> Cash On Hand </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Certificate Of Deposit (CD) <input type="checkbox"/> Money Market Account <input type="checkbox"/> Mutual Funds <input type="checkbox"/> Safe Deposit Box <input type="checkbox"/> Savings Bond <input type="checkbox"/> Stocks </td> </tr> </table>					<input type="checkbox"/> Bank/Credit Union Account (Checking) <input type="checkbox"/> Bank/Credit Union Account (Saving) <input type="checkbox"/> Joint Account <input type="checkbox"/> Bonds <input type="checkbox"/> Cash On Hand	<input type="checkbox"/> Certificate Of Deposit (CD) <input type="checkbox"/> Money Market Account <input type="checkbox"/> Mutual Funds <input type="checkbox"/> Safe Deposit Box <input type="checkbox"/> Savings Bond <input type="checkbox"/> Stocks													
<input type="checkbox"/> Bank/Credit Union Account (Checking) <input type="checkbox"/> Bank/Credit Union Account (Saving) <input type="checkbox"/> Joint Account <input type="checkbox"/> Bonds <input type="checkbox"/> Cash On Hand	<input type="checkbox"/> Certificate Of Deposit (CD) <input type="checkbox"/> Money Market Account <input type="checkbox"/> Mutual Funds <input type="checkbox"/> Safe Deposit Box <input type="checkbox"/> Savings Bond <input type="checkbox"/> Stocks																		
2. For each box checked above, complete the following information. <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 25%; text-align: center;">In Whose Name Is The Resource Listed</th> <th style="width: 15%; text-align: center;">Type Of Resource</th> <th style="width: 15%; text-align: center;">How Much Is It Worth</th> <th style="width: 45%; text-align: center;">Where Is The Resource (Include Name Of Bank Or Company, Where Money Is Held, Address Of Property, Etc.)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				In Whose Name Is The Resource Listed	Type Of Resource	How Much Is It Worth	Where Is The Resource (Include Name Of Bank Or Company, Where Money Is Held, Address Of Property, Etc.)												
In Whose Name Is The Resource Listed	Type Of Resource	How Much Is It Worth	Where Is The Resource (Include Name Of Bank Or Company, Where Money Is Held, Address Of Property, Etc.)																
3. Have you or anyone in your household received a Federal tax refund in the last twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Have you or anyone in your household received or do you or anyone in your household expect to receive a lump sum of money? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Does your name or the name of anyone in your household appear on a bank/credit union account with someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes , whose names are on the account? _____ b. Why is this name on the account? _____ c. Does someone else make deposits into this account? <input type="checkbox"/> Yes <input type="checkbox"/> No d. If yes , who and how much per month? _____ 6. Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months? <input type="checkbox"/> Yes <input type="checkbox"/> No				Are liquid resources \$1500 or less? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. If yes, complete supplement. 4. If yes, complete supplement. <input type="checkbox"/> Countable lump sum <input type="checkbox"/> Non-countable lump sum How was this verified? <input type="checkbox"/> Client statement <input type="checkbox"/> Bank statement <input type="checkbox"/> Other 6. If yes, complete supplement.															
For Office Use Only																			

IF YOU ARE APPLYING FOR SNAP BENEFITS ONLY, SKIP TO PAGE 13.

COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING FOR CHILD CARE ASSISTANCE

I. Child Care Assistance Program

1. Are you applying for the Child Care Assistance Program? ☐ Yes ☐ No
If yes, complete this page. **If no**, skip to page 11.

2. List all children who need care and the times each day that the care is needed. If school-aged children need care before and after school, list both times (for example: 7:00 a.m. to 8:00 a.m. and 3:30 p.m. to 6:00 p.m.).

Name Of Child	Age	Type Of Care	Provider's Name Address/Phone Number	Provider's Relationship To Child	Cost Of Care	Time Care Needed Each Day
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				
		<input type="checkbox"/> Child's Home <input type="checkbox"/> Provider's Home <input type="checkbox"/> Class A Center <input type="checkbox"/> Other				

3. List all children who attend or will attend Head Start, Pre-Kindergarten, Kindergarten, or school this school year. _____

4. Do any of the children listed above need specialized care because of a physical, mental, or emotional condition? ☐ Yes ☐ No

a. **If yes**, who? _____

b. For what condition? _____

For Office Use Only

Did the provider change? ☐ Yes ☐ No

How were special needs verified?

COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING FOR FITAP OR KCSP

J. FITAP or KCSP			For Office Use Only
1. Are you applying for FITAP or KCSP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete this page. If no, skip to page 13.			
HEALTH INSURANCE			
2. Can you or anyone in your household get health insurance through an employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
COLLATERALS			
3. Please complete the following information for two people who are not related to you who can verify your household situation.			
Name	Address	Daytime Phone Number	
CUSTODY			
4. If you are not the parent of the child(ren) for whom you are applying, do you have custody? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, complete the following information.			
Children For Whom You Have Custody	Type Of Custody	Effective Date Of Custody	
<i>A non-custodial parent is a parent who does not live in the home with his/her child. Tell us about the non-custodial parent(s) of each child living in your home. This includes both mother and father if you are not the parent of the child(ren). If a child's biological father and legal father are not the same person, give the requested information for both fathers. Use plain paper if you need more space.</i>			
5. Non-Custodial Parent Information			
Name	Social Security Number	Date of Birth	
Street Address			
City	State	Phone Number	
Employer			
Name(s) of Children			
Parental Relationship (relationship of children's parents): <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced 			

6. Non-Custodial Parent Information		
Name	Social Security Number	Date of Birth
Street Address		
City	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents): <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced		
7. Non-Custodial Parent Information		
Name	Social Security Number	Date of Birth
Street Address		
City	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents): <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced		
For Office Use Only		
Living in the home with qualified relative? <input type="checkbox"/> Yes <input type="checkbox"/> No Verified by: <input type="checkbox"/> Landlord statement <input type="checkbox"/> School records <input type="checkbox"/> Collateral <input type="checkbox"/> Other NCP: Complete form 4NCP and 4NCP Supplement, if applicable:		

Read Carefully And Sign Below

I certify under penalty of perjury that the information I have given on this application is true, complete, and correct to the best of my knowledge, including the information I have given regarding the U.S. citizenship or immigration status of all household members. I understand that I and any adult household member will be subject to disqualification and prosecution and will be required to repay ineligible benefits if we knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain financial, food, or child care assistance. By signing this application, I give permission for the release of information to the Department of Children and Family Services by any persons or agencies who have knowledge of my circumstances.

Remember, you must turn in proof of the information you reported on this application form and verification of your identity.

Your Signature (or mark)

Date Signed

Signature (or mark) of your wife or husband

Date Signed

Signature of Minor Unmarried Parent

Date Signed

If you, or your wife or husband, sign with an "X" mark, ask two people to witness the mark; if applicant is blind, ask three people to witness.

Witness

Witness

Witness

Signature of Person Who Helped You Complete this Form and His or Her Relationship to You

Signature

Relationship

Signature of Agency Representative

Date

I want to withdraw my _____ application because _____

Signature of Applicant

Date

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

Yes ☐ No ☐

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by the Department of Children and Family Services.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Do you need help from DCFS with completing the voter registration application form? Yes ☐ No ☐

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Louisiana Secretary of State, Commissioner of Elections, P.O. Box 94125, Baton Rouge, LA 70804-9125, Phone: (toll-free) 1-800-883-2805.

The Application for Assistance may be submitted by mail, fax, in person, or online through the CAFÉ Customer Portal. If submitted by mail, send to Department of Children & Family Services ES, Document Processing Center, P. O. Box 260031, Baton Rouge, LA 70826-9918. Fax to (225) 663-3164 or drop off your application at any local parish office. If you have questions regarding the application process, please contact the Customer Service Center at 1-888-LAHELPU (1-888-524-3578).

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended 5) reside in the state and parish in which you seek to register and vote.

INSTRUCTIONS FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

Box 1: Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

Box 2: Provide full name. Do not use initials for middle or maiden name.

Box 3: 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Boxes 5 & 13: You must provide your LA driver's license number or LA special identification card number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a LA driver's license number or LA special identification card number has been issued, and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Boxes 7, 11 & 12: The items 'race/ethnic origin', 'email' and 'phone' are not required but are helpful. Email is protected from disclosure by law.

Box 8: If you do not complete this item, your party affiliation will be listed as 'no party', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'no party'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 17: If you are using this form to request a change of name, you must print the name to be changed here.

Box 18: Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

NOTE: 1. If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

QUESTIONS? Call your Parish Registrar of Voters OR call the Department of State at 1-800-883-2805 or (225) 922-0900.

COMPLETE AND CHECK ALL APPLICABLE BOXES AND CUT HERE BEFORE MAILING.

LOUISIANA VOTER REGISTRATION APPLICATION				OFFICIAL USE ONLY				
LR-1 & 1M, FORM #100				Wd / Dist	Pct	Reg Type	In/Out	REG #
1 Are you a citizen of the United States of America? YES <input type="checkbox"/> NO <input type="checkbox"/> Will you be 18 years of age on or before election day? YES <input type="checkbox"/> NO <input type="checkbox"/> If you checked 'no' in response to either of these questions, DO NOT COMPLETE THIS FORM.								
2 NAME OF APPLICANT (PLEASE PRINT NAME)							GIVE LOCATION	
LAST		FIRST		FULL MIDDLE OR MAIDEN				
3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)								
HOUSE OR APT. NO. & STREET (IF RURAL, ROUTE & BOX NO.)				CITY OR TOWN		STATE		ZIP
If NO mail delivery to residential address, check here: ()							MAILING ADDRESS, IF DIFFERENT	
4 DATE OF BIRTH			5 * SOCIAL SECURITY # (CIRCLE ONE)		6 SEX (CIRCLE ONE)		7 ** RACE / ETHNIC ORIGIN (CIRCLE ONE)	
MONTH	DAY	YEAR	NO YES #		MALE FEMALE		WHITE BLACK ASIAN HISPANIC AMER. INDIAN OTHER:	
8 PARTY AFFILIATION (CIRCLE ONE)			9 APPLICANT'S PLACE OF BIRTH				10 MOTHER'S MAIDEN NAME	
DEM GRN LBT RFM REP NO PARTY OTHER (SPECIFY)			CITY OR TOWN PARISH OR COUNTY STATE COUNTRY					
11 **EMAIL			12 ** PHONE		13 LA DRIVER'S LICENSE / I.D. # (CIRCLE ONE)		14 Will you require assistance at the polls?(CIRCLE ONE)	
			HOME () DAY ()		NO YES #		NO YES IF YES, GIVE REASON:	
15 LAST RESIDENCE ADDRESS			16 PLACE OF LAST REGISTRATION			17 FORMER REGISTERED NAME, IF APPLICABLE		
ADDRESS			PARISH OR COUNTY STATE					
AFFIRMATION: I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than \$2,000 (\$5,000 for subsequent offense) or imprisonment for not more than 2 years (5 years for subsequent offense), or both. Any false statement may constitute perjury.								
18 SIGN YOUR NAME IN BOX AT RIGHT.								
DATE: / /								
19 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE.								
WITNESS SIGNATURE:					WITNESS SIGNATURE:			
* Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only; full # OPTIONAL. ** OPTIONAL								

ACADIA
568 NW Court Circle
Crowley, LA 70526-4363
(337) 788-8841
ALLEN
P. O. Box 150
Oberlin, LA 70655-0150
(337) 639-4966
ASCENSION
828 S. Irma Blvd. - #205
Gonzales, LA 70737-3631
(225) 621-5780
ASSUMPTION
P. O. Box 578
Napoleonville, LA 70390-0578
(985) 369-7347
AVOYELLES
312 N. Main St. - #E
Marksville, LA 71351-2409
(318) 253-7129
BEAUREGARD
P. O. Box 952
DeRidder, LA 70634-0952
(337) 463-7955
BIENVILLE
P. O. Box 697
Arcadia, LA 71001-0697
(318) 263-7407
BOSSIER
P. O. Box 635
Benton, LA 71006-0635
(318) 965-2301
CADDO
P. O. Box 1253
Shreveport, LA 71163-1253
(318) 226-6891
CALCASIEU
1000 Ryan St. - #7
Lake Charles, LA 70601-5250
(337) 437-3572
CALDWELL
P. O. Box 1107
Columbia, LA 71418-1107
(318) 649-7364

CAMERON
P. O. Box 1
Cameron, LA 70631-0001
(337) 775-5493
CATAHOULA
P. O. Box 215
Harrisonburg, LA 71340-0215
(318) 744-5745
CLAIBORNE
507 W. Main St. - Suite 1
Homer, LA 71040-3914
(318) 927-3332
CONCORDIA
4001 Carter St. - #4
Vidalia, LA 71373-3021
(318) 336-7770
DE SOTO
105 Franklin St.
Mansfield, LA 71052-2046
(318) 872-1149
E. BATON ROUGE
222 St. Louis - #201
Baton Rouge, LA 70802-5860
(225) 389-3940
E. CARROLL
P. O. Box 708
Lake Providence, LA 71254-0708
(318) 559-2015
E. FELICIANA
P. O. Box 488
Clinton, LA 70722-0488
(225) 683-3105
EVANGELINE
200 Court St. - Ste. 102
Ville Platte, LA 70586-4463
(337) 363-5538
FRANKLIN
Courthouse
6560 Main St.
Winnsboro, LA 71295-2750
(318) 435-4489
GRANT
Courthouse
200 Main St.
Colfax, LA 71417-1828
(318) 627-9938

IBERIA
300 S. Iberia St. - #110
New Iberia, LA 70560-4543
(337) 369-4407
IBERVILLE
P. O. Box 554
Plaquemine, LA 70765-0554
(318) 687-5201
JACKSON
500 E. Court St. - #102
Jonesboro, LA 71251-3400
(318) 259-2486
JEFFERSON
P. O. Box 10494
Jefferson, LA 70181-0494
(504) 736-6191
JEFFERSON DAVIS
302 N. Cutting Ave.
Jennings, LA 70546-5361
(337) 824-0834
LAFAYETTE
1010 Lafayette St. - #313
Lafayette, LA 70501-6885
(337) 291-7140
LAFOURCHE
307 W. 4th St.
Thibodaux, LA 70301-3105
(985) 447-3256
LASALLE
P. O. Box 2439
Jena, LA 71342-2439
(318) 992-2254
LINCOLN
100 W. Texas Ave.
Ruston, LA 71270-4463
(318) 251-5110
LIVINGSTON
P. O. Box 968
Livingston, LA 70754-0968
(225) 686-3054
MADISON
100 N. Cedar St.
Tallulah, LA 71282-3892
(318) 574-2193

MOREHOUSE
129 N. Franklin St.
Bastrop, LA 71220-3815
(318) 281-1434
NATCHITOCHES
P. O. Box 677
Natchitoches, LA 71458-0677
(318) 357-2211
ORLEANS
1300 Perdido St. - #1W23
New Orleans, LA 70112-2127
(504) 658-8300
OUACHITA
122 St. John St. #114
Monroe, LA 71201-7342
(318) 327-1436
PLAQUEMINES
P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 934-3620
POINTE COUPEE
211 E. Main St.
New Roads, LA 70760-3661
(225) 638-5537
RAPIDES
701 Murray St.
Alexandria, LA 71301-8099
(318) 473-6770
RED RIVER
P. O. Box 432
Coushatta, LA 71019-0432
(318) 932-5027
RICHLAND
P. O. Box 368
Rayville, LA 71269-0368
(318) 728-3582
SABINE
400 Capitol St. - #107
Many, LA 71449-3099
(318) 256-3697
ST. BERNARD
8201 W. Judge Perez - Rm. 104
Chalmette, LA 70043-1696
(504) 278-4231

ST. CHARLES
P. O. Box 315
Hahnville, LA 70057-0315
(985) 783-2731
ST. HELENA
P. O. Box 543
Greensburg, LA 70441-0543
(225) 222-4440
ST. JAMES
P. O. Box 179
Convent, LA 70723-0179
(225) 562-2330
ST. JOHN
1801 W. Airline Hwy.
LaPlace, LA 70068-3344
(985) 652-9797
ST. LANDRY
P. O. Box 818
Opelousas, LA 70571-0818
(337) 948-0572
ST. MARTIN
415 Saint Martin St.
St. Martinville, LA 70582-4549
(337) 394-2204
ST. MARY
500 Main St. - #301
Franklin, LA 70538-6144
(337) 828-4100
ST. TAMMANY
701 N. Columbia St.
Covington, LA 70433-2709
(985) 809-5500
TANGIPAHOA
P. O. Box 895
Amite, LA 70422-0895
(985) 748-3215
TENSAS
P. O. Box 183
St. Joseph, LA 71366-0183
(318) 766-3931
TERREBONNE
P. O. Box 9189
Houma, LA 70361-9189
(985) 873-6533

UNION
P. O. Box 235
Farmerville, LA 71241-0235
(318) 368-8660
VERMILION
100 N. State St. - #120
Abbeville, LA 70510
(337) 898-4324
VERNON
P. O. Box 626
Leesville, LA 71496-0626
(337) 239-3690
WASHINGTON
Courthouse Bldg.
900 Washington St.
Franklinton, LA 70438
(985) 839-7850
WEBSTER
P. O. Box 674
Minden, LA 71058-0674
(318) 377-9272
W. BATON ROUGE
P. O. Box 31
Port Allen, LA 70767-0031
(225) 336-2421
W. CARROLL
P. O. Box 71
Oak Grove, LA 71263-0071
(318) 428-2381
W. FELICIANA
P. O. Box 2490
St. Francisville, LA 70775-2490
(225) 635-6161
WINN
119 W. Main St. - Room 105
Winnfield, LA 71483-3238
(318) 628-6133

OFFICIAL USE ONLY

Address Change

Name Change

Party Change

Remarks

Circle One: PA-In Person PA-By Mail

MV RG SDA SS(Disability)

Received by: _____

PLACE IN AN ENVELOPE AND MAIL TO YOUR
REGISTRAR OF VOTERS